Do Not Staple!

KENTUCKY EMPLOYEES HEALTH PLAN
PY 2007

HEALTH INSURANCE and SPENDING ACCOUNT
APPLICATION FOR ACTIVE EMPLOYEES

INSURANCE COORDINATOR SECTION

__/__/0__ Coverage Effective Date _____ Company Number

__/__/__ Deduction Start Date (BOEs ONLY)

Reason for Application:

☐ < New Employee ☐ < Open Enrollment ☐ < New Group ☐ < FSA Only
☐ < QE* ☐ < Previously Waived* ☐ < Other*

* If you previously waived, or marked "Other" or "QE" above, enter the Qualifying Event date AND a description of the Qualifying Event: _____ Date _____ Qualifying Event Description

SECTION I: DEMOGRAPHIC INFORMATION → Please PRINT

___-___-____ Social Security Number __/__/____ Date of Birth (MM/DD/YYYY)

Smoking Status *(Required)*
Have you smoked in the last 2 months? ☐ < Yes ☐ < No

_____
NAME (First, MI, Last)

Gender
☐ < Male
☐ < Female

Marital Status
☐ < Married
☐ < Single

_____
Mailing Address

_____ City, State, Zip Code _____ County of Residence _____ Country / Mail Code, if not USA

_____ Planholder's HOME Phone Number _____ Planholder's WORK Phone Number _____ Planholder's Email Address

_____ Hire Date _____ Employer Name _____ Work County

SECTION II: PLAN SELECTION → *If you wish to waive coverage, skip to Section V below*

1. Option (Check only one)
☐ < Commonwealth Essential
☐ < Commonwealth Enhanced
☐ < Commonwealth Premier
☐ < Commonwealth Select

2. Level of Coverage
☐ < Single
☐ < Parent Plus
☐ < Couple
☐ < Family

3. Cross-Reference Payment Option
(Available for Family Coverage Only)
☐ < Yes
If Yes, you must complete Sections III and IV

SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION → *If you selected Single coverage, skip to Section VI*

Social Security Number	Name (First, MI, Last)	Gender (Circle one)	Date of Birth (MM/DD/YYYY)	Relationship Code
		M F		
		M F		
		M F		
		M F		
		M F		

SECTION IV: CROSS-REFERENCE INFORMATION → *Complete ONLY if you checked Yes in Section II, box 3*

Your Spouse's Company Number: ***(Required)***	Has your spouse smoked in the last 2 months? ***(Required)***	Is your spouse a Hazardous Duty Retiree?	Your spouse's Hire Date or Retirement Date:	Your spouse's Deduction Start Date (If BOE employee):
_____	☐ <Yes ☐ <No	☐ <Yes ☐ <No	_____	_____

SECTION V: WAIVER → *Complete this section only if you did not select coverage in Section II*

Do you wish to waive your health insurance coverage and have the employer contribution of $175 per month deposited into a Health Reimbursement Account (HRA)? ☐ < Yes

KENTUCKY EMPLOYEES HEALTH PLAN

HEALTH INSURANCE and SPENDING ACCOUNT APPLICATION FOR ACTIVE EMPLOYEES

PAGE 1 Instructions

Reason for Application

- **New Employee**: Check this box if you are a new employee.
- **Open Enrollment**: Check this box if you are filling out this application for Open Enrollment.
- **New Group**: Check this box if your employer is joining the Kentucky Employees Health Plan (KEHP) for the first time.
- **FSA Only**: Check this box if you are enrolling in a Flexible Spending Account for the first time due to a Qualifying Event (QE).
- **QE**: Check this box if you are making a change to your overage Option, as permitted by a valid QE.
- **Previously Waived**: Check this box if you previously waived your health insurance coverage and have now experienced a QE that allows you to select coverage. You must provide the date and description of the qualifying event in the spaces provided below. All other QEs do not require an application and do require a Dependent Add or Drop form only. You may request a Dependent Add or Drop form from your Insurance Coordinator (IC) and must provide supporting documentation, as required.
- **Other**: Check this box if none of the listed options apply. The IC must provide a date and an explanation if "Other" is selected.

***TO THE INSURANCE COORDINATOR**:* Complete the information requested within the box in the top right corner of the application.
For ALL employees - Enter the effective date of coverage and the employee's company number.
For BOE employees only – Enter the Deduction Start Date.

SECTION I: DEMOGRAPHIC INFORMATION – Please PRINT clearly.

- Enter the planholder's Social Security Number, Date of Birth, Name (First, MI, Last), Address (including County of Residence), Smoking Status, Gender, Marital Status, Planholder's HOME and WORK Phone Numbers, Planholder's Email Address, if available, Hire Date, Employer's Name and Work County. **Note:** If the smoking status flag is not checked, this application will be Pended until the information is provided. **The smoking status that you select during Open Enrollment or as a new employee will remain for the entire Plan Year. A change in your smoking status is NOT a qualifying event.**

SECTION II: PLAN SELECTION

1. **Option**: Mark the option you are selecting. For a description of each option, see the Health Insurance Handbook. Select only one.
2. **Level of Coverage**: Mark the level of coverage you are selecting. For a description of each level of coverage, see the Health Insurance Handbook. Select only one.
3. **Cross-reference Payment Option**: If you wish to elect the cross-reference payment option, check Yes and complete Sections III and IV. This payment option is only available for Family coverage. ONLY ONE application is required.

SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION

Provide the information requested for every dependent you are enrolling (including your spouse if electing the cross-reference payment option). If you need additional space, use Page 1 of another health insurance application.

Relationship Code: Enter the appropriate relationship code as follows:

SP Spouse (your eligible spouse).
CH Child (your eligible child, step child, adopted child, foster child or your grandchild) age 0 to 23 (To enroll, a dependent must be age 23 or less and not turn 24 during the coverage year).
DD Disabled, Dependent Child (your eligible disabled child). If your disabled dependent child is 24 years old or older, your health insurance carrier will request evidence of his/her disability annually.
CO Court Ordered Dependent Child (an eligible dependent child that you are court ordered to carry on your health insurance.

SECTION IV: SPOUSE'S CROSS-REFERENCE INFORMATION

Complete this section ONLY if you and your spouse are selecting the cross-reference payment option. Enter your spouse's company Number (required), smoking status (required), hazardous duty retiree indicator, hire date or retirement date (if applicable), and the deduction start date (only needed if the planholder elects to start a cross-reference payment option with a school board employee.

SECTION V: WAIVER

Complete this section ONLY IF YOU DID NOT SELECT COVERAGE in Section II.
You must mark Yes if you are electing to waive health coverage for Plan Year 2007 and direct the employer contribution of $175 per month into an HRA.

If you do not mark Yes in this section, you will not receive the employer contribution of $175 per month for Plan Year 2007.

PY **2007**

Planholder's SSN

SECTION VI: FLEXIBLE SPENDING ACCOUNTS (FSA) → Enrollment in an FSA is OPTIONAL

If you are an employee of a health department or certain quasi agencies, this section does not apply to you. You must contact your insurance coordinator regarding your FSA enrollment process.

Health Care → All amounts must be divisible by two.

The **minimum** allowable monthly contribution is $10 The **maximum** allowable yearly contribution is $2,880

Planholder	**Spouse** → If paying by cross-reference and spouse's FSA program is administered by the KEHP
Total Employee Contribution for Plan Year _____	Total Spouse Contribution for Plan Year _____

Dependent Care → All amounts must be divisible by two.

Minimum allowable monthly contribution - $10 **Maximum** allowable yearly contribution - based on tax filing status

Tax Filing Status:

☐ < Married, filing separately (max = $2,500) ☐ < Married, filing jointly (max = $5,000) ☐ < Single, head of household (max = $2,500)

Planholder	**Spouse** → If paying by cross-reference and spouse's FSA program is administered by the KEHP
Total Employee Contribution for Plan Year _____	Total Spouse Contribution for Plan Year _____

HumanaAccess℠

Upon enrolling in an HRA or an FSA, you will receive the HumanaAccess Visa debit card at no cost to you and with no transaction fee.

SECTION VII: COORDINATION OF BENEFITS

Are you or any of your dependents listed on this application covered under another health insurance plan? ☐ < Yes ☐ < No

SECTION VIII: AUTHORIZATION AND CERTIFICATION

* I understand that my signature on this application creates a legal and binding contract between myself, the Department for Employee Insurance and the TPA.
* **I understand that if my spouse and I elect the cross-reference payment option, our level of coverage (Family) cannot change if one of us terminates employment, and the remaining spouse will pay the full family contribution.**
* I understand that all benefits for my eligible dependents and me will be provided in accordance with the plan contract.
* I agree to abide by the terms and conditions governing membership and receipt of services from the plan in which I have enrolled.
* I understand that the elections indicated on this application may not be changed or canceled during the plan year, with the exception of certain Qualifying Events.
* I authorize my employer to deduct from my earnings the amount required to cover my share of the coverage I have selected.
* I elect to have the employee contribution for health coverage deducted on a pre-tax basis unless I sign a Post-Tax Request form.
* I understand that enrollment in an FSA is optional and that by completing Section VI of this application, I am enrolling in an FSA, if eligible to participate.
* Regarding my FSA, I understand that any dependents for which I claim reimbursement are Section 152 dependents as defined by the Internal Revenue Code.
* Regarding my FSA, I further understand that any unused amount remaining in my spending account at the end of the plan year cannot be carried forward to the next year due to the Commonwealth's Cafeteria Plan Document.
* I understand that I have a 90-day run-out period (until March 31) for reimbursement of eligible FSA expenses incurred during my period of coverage.
* I understand that the misrepresentation of any information on this application with the intent to defraud is a fraudulent insurance act, which is a crime, and any material misrepresentation or omission may be used to reduce or deny a claim or to terminate my coverage.
* I have fully read the materials provided to me. My signature below certifies that the statements on this form are true and complete to the best of my knowledge.

_____ _____

Employee Signature Date

_____ _____

Spouse Signature – ***REQUIRED* if electing the cross-reference payment option** Date

.....

I understand that any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance containing any forged signature or incorrect signature date thereto commits a fraudulent insurance act, which is a crime. I understand that I can be held responsible for any fraudulent act that is the result of a forged signature or incorrect signature date that I could have prevented while acting within my duties related to the KEHP. My signature below certifies that all signatures and signature dates affixed to this contract are correct to the best of my knowledge.

_____ _____

Employee's Insurance Coordinator Signature Date

_____ _____

Spouse's Insurance Coordinator Signature – ***REQUIRED* if electing the cross-reference pmt. option** Date

KENTUCKY EMPLOYEES HEALTH PLAN

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PAGE 2 Instructions

Enter the social security number of the planholder in the spaces provided on the top right hand corner of Page 2.

SECTION VI: FLEXIBLE SPENDING ACCOUNT (FSA)

- This section can only be completed by employees of state agencies and boards of education.
- If you are an employee of a health department or quasi-governmental agency, you cannot use this section to enroll in an FSA. You must contact your IC regarding your FSA enrollment process and deadlines.
- Enrollment in an FSA is OPTIONAL and is completely funded from employee's funds (no employer funds are directed into an FSA). In order to direct an amount into an FSA you must enroll, either online or by completing this section (for state employees and boards of education) by the deadline.
- All amounts entered in this section are yearly amounts.

Health Care
All amounts must be divisible by two.

PLANHOLDER
Total Employee Contribution for Plan Year: Enter the total employee contribution amount for the entire coverage period.

SPOUSE (For cross-reference payment option only)
Complete this section with YOUR SPOUSE'S Flexible Spending Account information, only if your spouse meets ALL of the following:

- He/she is a state employee or a board of education employee;
- He/she is electing the cross-reference payment option; and
- He/she is electing to enroll in the available FSA program. Enrollment in a Flexible Spending Account is OPTIONAL.

Total Spouse Contribution for Plan Year: Enter the spouse's total contribution amount for the entire coverage period.

Dependent Care
Mark the tax filing status that applies to you (or to both of you if your spouse is eligible and is also enrolling).

PLANHOLDER
Total Employee Contribution for Plan Year: Enter the total employee contribution amount for the entire coverage period.

SPOUSE (For cross-reference payment option only)
Total Spouse Contribution for Plan Year: Enter the total contribution amount for the entire coverage period.

Humana*Access*: If you are eligible and elect to participate in an employer-funded HRA (for waivers or for employees selecting the Commonwealth Select Plan) or in an employee-funded FSA Program (for state agencies and boards of education employees), you will receive the Humana*Access* card at no cost to you and with no transaction fee. This is a free service offered to you.

SECTION VII: COORDINATION OF BENEFITS

Check whether or not you, or any of the dependents listed on this application, are covered under another health insurance plan.

SECTION VIII: AUTHORIZATION AND CERTIFICATION

- **Read each statement carefully**. After you have read and understood the statements, sign your name and enter today's date in the lines provided. If you are electing the cross-reference payment option, your spouse MUST also sign and date the application.
- Your cross-referenced spouse must have his/her insurance coordinator(IC) sign this form before you return it to your IC.
- Your cross-reference application will not be processed without the four required signatures and dates.

REMEMBER THAT YOU HAVE THE OPTION TO ENROLL ONLINE. ENROLLING ONLINE IS EASY, FAST AND SECURE. IF YOU ENROLL ONLINE, YOU WILL RECEIVE INSTANT CONFIRMATION THAT YOU HAVE ENROLLED!